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by

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Preface

The author is a USAF flight surgeon specializing in Aerospace Medicine, a sub category of Preventive Medicine. As a Major in the USAF medical corps, I had the special opportunity of leading HQ USAFE's Executive Health Program. Much to my surprise, there were no guidelines, regulations, doctrine, or standard operating procedures. There was no clear funding line and no written history about either the origins of the so-called "Program" or guidance to even understand why and who established such a "Program." It was staggering for me to suddenly realize that the "Program" that I was entrusted to execute, had neither a mission statement nor Air Force "buy-in." I slowly deduced that the executives I was treating were unaware of any "Program" at all. Instead they were being treated by hit-and-miss medical care providers. In many instances, politics dictated when, where, and how medical encounters were executed. When I was unable to locate executive's medical records, I had to ask the question. "Who's in charge of these people?" There was no answer to follow and I was now in charge of what I likened to a "Black Program."

My first challenge was to get information, while continuing to practice medicine in a manner that was unusual and unprecedented to me. I would execute practices that I would later condemn for lack of support and guidance. As I began to uncover the history, it was to my good fortune that the civilian holding the longest tenure and collective memory of the "Program" was my greatest source of information. This one individual

fell prey to a political debacle that highlighted the fallacy that even such a "Program" existed. Then was it apparent that I was not special by any means in being selected to head this "Program" but rather was in the wrong place at the wrong time. The civilian aforementioned, whom I was totally reliant for historical information and guidance, was himself under investigation by the USAF Inspector General for accusations of derelict and medical malpractice. I was then faced with an even grimmer dilemma; "how much can I trust this individual as my sole source of information?"

The aforementioned individual was exonerated of all allegations and I was fortunately in a position to appreciate his advice, at least from an official standpoint. This story is politically infested with cases of unintentional malpractice and bureaucracy blunders that prevented proper medical care from being conducted in a manner consistent with accepted medical practice. It is about assumptions, perceptions, and clear lack of doctrine as well as programmatic deficiencies. Although there is no happy ending, there is a great deal of experience, evidence, and insight to organize a first-class executive health-care system for the privileged few. Whether such a program is politically correct or popular with those non-executive patients, or the day-to-day health care providers, cannot stop the reality that such a program must be ordained and formally established and revealed to the target community, i.e., the flag-ranking executives themselves. Case studies with retrospective analyses, insight gleaned from world-class organizations, and an application of executive medical care as an Occupational Medicine responsibility will set the stage for a proposed USAF Executive health-care program that has attainable goals and "teeth."

It is noteworthy, that at the time of this research paper, the USAF Surgeon General has ordered the abolition of the Air Force Medical Corps involvement in so-called “Executive Medicine.” The practice of Executive Medicine is intended to be officially halted as of 01 Jun 98, coincident with the release of this product. The reasons given are that no officer, regardless of grade, will be treated any differently, medically. “United States Code (USC), Title 10, Sections 1074, 1076, and 1097 authorize access to healthcare for DoD beneficiaries, but do not differentiate access by grade or rank.” This document goes on to state that “The Secretary of the Air Force (SAF) has received complaints on discrimination of access to Air Force healthcare based on grade or rank. The position of the Air Force Judge Advocate is that healthcare is a benefit and access to care in Medical Treatment Facilities (MTFs) is predicated on statute, policy guidance, and medical necessity, i.e., emergency care or urgent care.”

With this official announcement and decision, the existing Executive Health Care Program, as it is today, will be eliminated. What effect this will impose upon the Executives and the healthcare providers remains to be seen. Hopefully, this research paper will enlighten many to the untoward consequences of “The VIP Syndrome.” Perhaps the decision to eliminate the Executive Healthcare Program will bring about positive results because of the inherent flaws already built into the existing Executive Healthcare Program. Or, it will offer a plan to formally establish a program that is really effective in meeting the needs of the flag-ranking officers of the USAF.

Abstract

It is often assumed by most military and civilians that flag-ranking officers, and their families, enjoy privileged health care, both accession and quality of care. As an experienced physician in charge of a Major Command's Executive Health Program, the author's experience is far from that perceived and assumed. In fact, quite the opposite prevails. Although there are "Executive Wellness" and "Health" programs in existence in the USAF, there is clear lack of doctrine and awareness of such programs. The result is less-than-optimal health care delivery to flag-ranking officers and their families. In some instances, inferior to that provided to the lowest ranking individual in the service. The article goes on to explore the origin of executive health care, case studies highlighting major medical errors committed with analyses that follow, a broad look at world-class executive establishments, and finally, a proposal for an executive health care system for the USAF in the 21st century.

Chapter 1

Introduction

Health care of executives is of paramount importance to the institutions they serve. In the corporate sector, stock prices can fluctuate dramatically during a health crisis of a key Corporate Executive Officer (CEO). In government institutions, the welfare of the president captivates the interest of the entire world. An assassination or health care problem, even though minute, can hold audiences literally glued to news media on White House announcements.¹

An even greater issue, though, is the means, manner, and frequency in which very important persons (VIPs) receive health care. This paper draws on well-documented cases of preventive-level health care encounters and a phenomenon called “The VIP Syndrome.” The “VIP Syndrome” is defined as “anyone whose presence in the healthcare setting, by virtue of fame, position, or claim on the public interest, may substantially disrupt the normal course of patient care.”² This paper incorporates vignettes of historical cases and those personally encountered by the author in the USAF Medical Corps.

A general officer is, in essence, a VIP. The author would even venture to estimate that the “VIP” status of a general military officer, can be even more disruptive to the smooth delivery of healthcare than a CEO.

The disruption that a VIP causes upon entering a health care encounter is, to a large degree, dependent upon the personality of the VIP patient and the emotional stability of the health care provider. Many healthcare providers can undergo an initial period of cognitive paralysis, being awestruck by the celebrity status of a VIP patient. Such a condition can lead to a cascade of events that can end in catastrophe. Conversely, the VIP, because of his or her status, can be predisposed to intimidating those who serve him/her, especially if they are acutely ill and regress emotionally to a defensive behavior. Such patients can thus begin dictating their own healthcare disposition, e.g., “requesting” certain procedures be foregone, or “requesting” others be performed. The primary physician needs to have experience and maintain his/her professional integrity under these intimidating circumstances lest the VIP usurps the physician’s authority and subsequent treatment.³

There is a paucity of literature addressing the protocol and healthcare delivery to VIPs, but even less is published concerning general officers. Thus, it is default, by design, that the author presents civilian case studies in greater abundance than military encounters. Every attempt has been made to extrapolate the essence of civilian encounters to those anticipated in the military sector. In fact, the author’s experience concludes that there are few, if any, generic differences between the emotional, environmental, behavioral, logistical or healthcare practices between civilian VIP encounters and those in the military.

The importance of this paper is to articulate to the military healthcare community the phenomenon of the “VIP Syndrome.” Few health care professionals receive even cursory training in this subject. To instruct medical students and physicians to simply “treat a

VIP as you would anyone else” is reckless and foolhardy. Whether or not VIPs deserve “special” healthcare than average patients is discussed in the content of this paper. But if nothing else grasps the attention of the reader, perhaps the outcome of our predecessor’s experiences, and their, and the author’s suggestions, will provide an awareness of the complexity of VIP healthcare, lest the unprepared learn the hard way.

Notes

¹ Robert E. Strange, “The VIP with Illness, *Military Medicine*, July, 1980: 473-475.

² J. A. Block, “Beware of the VIP Syndrome, *Chest*, October 1993: 104(4); 989.

³ E. H. Feur and S. R. Karuso, “A Star-Struck Service: Impact of the Admission of a Celebrity to an Inpatient Unit,” *The Journal of Clinical Psychiatry* (1978): 39: 743-746.

Chapter 2

Who Killed President Lincoln?

Abraham Lincoln, the 16th President of the United States, was shot on Good Friday, April 14, 1865. Just five days earlier, General Robert E. Lee had surrendered to General Ulysses S. Grant. Lincoln was in a mood to celebrate the war's end. In fact, he remarked to his wife on this day "I have never felt so happy in my life."¹

A conspiracy was looming to assassinate Lincoln and Grant. The conspirators included Lewis Paine, a confederate war veteran, George Atzerodt, a German-born carriage maker, David Herold, a Washington drug clerk, and John Surrat, a confederate courier whose mother owned the boarding house where the group, led by John Wilkes Booth, met frequently. Booth was a 26-year-old actor and Southern sympathizer. The plan was for Paine and Herold to kill Secretary of State William Seward at his home. Similarly, Atzerodt was to kill Vice President Andrew Johnson. Booth was to kill Lincoln, all occurring simultaneously on the evening of April 14. It was Booth's delusion that the decapitation of the Union government would give Lee the courage to reconvene his Southern Army and march on Washington.

That night, the Lincolns invited General and Mrs. Grant to attend with them Tom Taylor's popular comedy, "Our American Cousin," playing at Ford's Theater. The Grants declined the invitation in order to visit their daughter in New Jersey. Mr. and

Mrs. Lincoln arrived late after the play had started. They were escorted to the Presidential box located immediately stage left and elevated 12 feet.

Booth entered the theater and gained access to the dress circle adjacent to the Presidential box. The President's bodyguard, John J. Parker, had "abandoned" his post so that he could get a closer view of the stage. With this, Booth entered the corridor behind the box, ascertained the President's position through a peephole that he'd drilled earlier. As the play was reaching a loud climax, filling the theater with hilarious laughter and applause, Booth approached Lincoln from the right. He fired one shot into the back of Lincoln's head at point blank range using a .44 caliber Derringer pistol. Booth threw the pistol to the floor and drew his 7-inch hunting knife, stabbing Lincoln's friend Major Rathbone, seated next to Lincoln. Rathbone had attempted to apprehend Booth. Booth jumped the 12 feet off the balustrade. He landed sprawled on the stage fracturing his left leg. As he hobbled off the stage, he yelled "Sic Semper Tyrannis," or "Thus Always to Tyrants."

Ford's Theater was in utter chaos. Captain Oliver Match, an eyewitness and a veteran of the Civil War noted," the crowd went mad, a wilder night I never saw, not in battle even." In the box, Mary Lincoln clutched the slumped president. A spectator in the audience climbed over people and chairs and leaped into the box. His name was Charles A. Leale, MD, a 23-year -old Army surgeon who was in charge of the Wounded Commissioned Officer's Ward at the U.S. Army General Hospital in Washington, D.C. Mary Lincoln asked, "Oh doctor, is he dead? Can he recover? Will you take charge of him?" Dr. Leale conducted a careful survey of Lincoln to determine where or in how many places he had been wounded. Placing a hand on Lincoln's right wrist, he felt no

pulse. He removed Lincoln from his chair and placed him on the floor. In doing so, he noted a small amount of blood on Lincoln's left shoulder. Recalling the knife he saw in Booth's hand, and never having heard the shot over the applauding theater, Dr. Leale first estimated Lincoln had been stabbed. He cut away Lincoln's shirt and coat. At that exact moment a man assisting Dr. Leale saw the pistol that Booth had discarded. Now with the shirt cut away, Dr. Leale found no stab wound. He checked Lincoln's pupils and one was dilated. He immediately suspected a head injury. He combed his fingers through Lincoln's hair until he discovered a single entrance wound to the left posterior aspect of the skull. He then removed a small piece of clotted blood from the wound orifice. As the President was breathless and pulseless, Leale inserted two fingers in Lincoln's mouth to depress the tongue and open his airway. He positioned assistants at each of Lincoln's arms and then instituted today's equivalent of CPR by stretching the lungs and diaphragm to respire the patient. Dr. Leale performed a crude cardiac massage (by today's standard) by applying an intermittent pressure under the left subcostal ("rib line") margin. Leale began mouth-to-mouth resuscitation. Eventually, Lincoln's pulse and respiration returned! Leale told Mrs. Lincoln "his wound is mortal; it is impossible for him to recover."

By this time, another Army surgeon who had been lifted to the box by the people joined Dr. Leale. Dr. Charles Sabin Taft discussed Lincoln's emergency with Dr. Leale. Both agreed to remove him from the theater where danger could still loom. Someone suggested taking Lincoln back to the White House, but Leale didn't believe Lincoln could survive the seven-block ride over cobblestone streets. It was eventually decided to transport Lincoln across the street to 453 10th Street, a house belonging to citizen

William Pederson, a Washington merchant tailor. The bed was too small to accommodate Lincoln's 6'4" stature so he was straddled diagonally. An all night vigil began.

The exact order of events from this point is in some dispute. Some authorities report that the Surgeon General, Dr. (General) Joseph K. Barnes, was summoned immediately by Mrs. Lincoln along with the Assistant Surgeon General Charles H. Crane, every member of Lincoln's cabinet, Lincoln's family physician, Dr. Robert King Stone, and the President's pastor, Reverend Phineas D. Gurley. Dr. Beales' account of the story is that he had suggested notification of the Surgeon General for protocol reasons.

In any case, Dr. Leale had kept Lincoln alive, at least until the arrival of the aforementioned "guests" occupying a room 17 1/2 feet by 9 1/2 feet. Dr. Leale had hot water bottles placed around Lincoln and had on several occasions used his little finger to push the plug of bone in the skull wound slightly inward to allow the extravagation of blood that he suspected was causing a high intracranial pressure. It is noteworthy to mention here that Dr. Leale was the youngest physician in attendance of Lincoln and the only physician to have received any current therapeutic instruction on head injuries, since such knowledge was new to medicine. Leale remembered the lecture he received as a recent graduate of medical school and the field casualties of Civil War head wounds were cases well known to him. In any case, his authority as medical team chief was usurped by dignitary medical officers who hadn't practiced medicine for many years. Despite Dr. Leale's objections, Dr. Taft, who had initially assisted Leale at the Ford Theater, and the more senior surgeon, insisted upon pouring brandy and water down Lincoln's throat. Leale warned it could cause strangulation, but Taft proceeded anyway and resulted in Lincoln undergoing an attack of Laryngeal spasm. But Lincoln survived this treatment.

Surgeon General Barnes, with the assistance of Lincoln's family physician, Dr. Stone, began probing the skull wound with their fingers. They noted that as long as the wound freely oozed blood, Lincoln's pulse and respiration continued. Whenever the clot was allowed to form over the wound's opening, Lincoln's breathing slowed and his pulse became feeble.

At 2 a.m., Surgeon General Barnes inserted a silver probe into Lincoln's skull wound. Dr. Leale was aghast. His recent medical training in head injuries clearly argued against this barbaric procedure. At about two inches into the skull, the probe struck an obstruction, thought to be a plug of bone. The surgeons fetched a longer probe in an attempt to remove the bullet. A Finch Nelaton probe was introduced until it was felt to have met the bullet that was lying superior to the left orbital plate. Dr. Taft described the President as follows:

"Eyes entirely closed, the left pupil much contracted, the right widely dilated: Total insensibility to light in both. The left upper eyelid was swollen and dark from effused blood; discoloration from effusion began in the internal canthus of the right eye, which became rapidly discolored and swollen with great protrusion of the eye."

It has been estimated that 90 visitors were in and out of that tiny room during the night. The president's vital signs did not vary until 5:30 a.m., when the wound no longer oozed. Then his pulse became faint, and his breathing prolonged and labored. Lincoln's groans echoed throughout the filled house. Doctors remained surrounded around Lincoln. Dr. Leale, in his subjugated role, held Lincoln's right hand to "let him know in his blindness, if possible, that he was in touch with humanity and had a friend." The

battle for life ended at 7:22 a.m. on April 15, 1865, when Dr. Barnes perceived no carotid pulse and declared Lincoln dead.

Noteworthy of this event are first, a pen-and-ink sketch of the resuscitation effort throughout the vigil, rendered by Hermann Fuber, a hospital steward serving the Surgeon General's office and witness to scenes of that night. Ironically, every physician is depicted except Dr. Leale. Second concerns the bed and room in which Lincoln died. It had been used by John Wilkes Booth preceding the assassination. Third, Major Rathbone who was stabbed in the theater trying to apprehend Booth, nearly died of exanguination as medical attendants ignored his wound. Fourth, the Lincolns had originally invited General and Mrs. Grant to the play. The Grants had declined the invitation in order to visit their daughter when in reality, Mrs. Grant intensely disliked Mrs. Lincoln. Furthermore, General Grant had a very competent and well-respected bodyguard, very opposite Lincoln's. It has been speculated had Grant's bodyguard been present, Booth would have never gained entrance to the President's box and thus avoided the assassination.

Recently, neurosurgeons performed a very detailed analysis of Lincoln's medical condition, treatment, and prognosis.² Their conclusion was that the young Army surgeon, Dr. Leale, was Lincoln's best hope of survival. They further condemned the Surgeon General and his senior assistants for probing Lincoln's skull. An autopsy performed on Lincoln upon his death revealed that the probe was directed to the opposite side of the wound's path. The damage from the probe equaled that of the bullet. They hypothesize that if Lincoln would have been left alone, he would have survived, albeit with significant neurological sequelae from the bullet wound.

The foregoing chapter is a segue into a phenomenon in medicine known as the “VIP Syndrome.” This stark example of medical incompetence should serve as a signal that VIPs pose a unique challenge to the attending physician. The foregoing chapter will begin a discussion on the “VIP Syndrome” in the USAF Medical Corps and its relevance to the USAF “Executive Health Programs.”³

Notes

¹ G.J. Flattman and P. J. O’Leary, “Lincoln’s Last Hours,” *The American Surgeon* (June 1997): 63: 561-564.

² Ibid

³ Walter Weintraub, “The VIP Syndrome: A clinical Study in Hospital Psychiatry,” *Journal Nervous Mental Disorders* (1964):138: 181-193.

Chapter 3

The USAF's Executive Health Program

The USAF does not have a formally sanctioned Executive Health Program. Rather, Military Treatment Facilities (MTFs) have, for many years, treated flag-ranking officers in a variety of means. The protocol aspect of each MTF rests largely upon its location and accessibility to flag officers and other VIPs, such as embassy personnel, ambassadors, and retired flag-ranking officers and their families. In isolated or small bases, the MTF may very seldom encounter what would be considered a “VIP” patient, except possibly for a wing commander at the colonel grade. In these cases, it is usually the practice to forward these patients to the MTF commander if he or she is a physician, or to the MTF's Flight Surgeon's Office (FSO).¹

The FSO has been a favored location and setting for the treatment of many varieties of dignitaries. Its quick, flexible accessibility, along with flight surgeons that possess, by the nature of their occupation, a close allegiance with military pilots and their families, makes them a known quantity. Consequently, the majority of senior USAF officials are rated aviators and have usually enjoyed a long history of direct flight surgeon care from the time of their accession into the Air Force. It is this close relationship between the senior aviator and the flight surgeon that biases the “VIP” patient to perceive the flight surgeon as the appropriate authority for their care.

Thus, USAF flight surgeons, by and large, acquire more experience dealing with the pressures of providing healthcare to senior commanders and USAF general officers than other medical officers provide.

In a larger setting, for example a Regional hospital, the frequency of senior officer patient encounters is greater. Additionally, the ready availability of specialists to consult upon is very advantageous for efficient and fast delivery of care. It is these larger facilities that have over the years, evolved a process or system of facilitating a “smooth” healthcare encounter to the VIP patient. Further, these processes have grown at some institutions into separate “programs” frequently called “Executive Healthcare.” Such facilities, e.g., Wilford Hall Medical Center, possess a protocol officer and employ a primary care provider to provide care for General Officers and their spouses, as well as some other “VIP” dignitaries.² It is, nevertheless, unfortunate that these so-called Executive Healthcare Programs have never been formally ordained. In point of fact, just recently, a litany of Inspector General complaints forced the USAF Surgeon General to dismantle all USAF “Executive Healthcare Programs” by United States Code (USC), Title 10, Sections 1074, 1076, and 1097. This regulation states that “access to healthcare for DoD beneficiaries will not be by grade or rank.” This will require general officers and other VIPs to access the USAF medical system, as do all other patients. It doesn’t preclude protocol arrangements, but it will affect the long tradition of what many consider the “VIP Clinic.”

It is very noteworthy to address these now former “Executive Healthcare Programs.” Initially, they evolved as a means to assure that VIP officers could quickly and “privately” obtain fast, acute healthcare remedies. Overall, productively of the program

itself was very low in order to maintain flexibility. For example, an annual health examination for a general officer and their spouse would be conducted within 3-4 hours, but with a buffer of time in order to deal with unexpected laboratory tests and specialty consultations. A complicated encounter with a VIP could, in some cases, stretch out an entire day, and even beyond. In order to handle this, “Executive Health Programs” limited the number of dignitary visits in their facilities to one, two, or possibly three in one day, in order to maintain the flexibility to deal with extensive testing and consultation. This has been less than optimal in terms of productivity. Because DoD or the Department of the Air Force does not formally sanction these programs, funding comes from the MTF’s budget.³

One of the mainstays of these “Executive Health Programs” has become the Annual Physical Examination. This has been a two-edged sword. On one hand, it provides an extensive physical examination for the general officer dignitary and his/her spouse. But the anomaly that developed, both between the caretakers and the patients, was that acute illnesses that occurred between annual visits, provided no continuity of care. Both the program’s managers and the executive patients began seeing “Executive Health” as a point of contact for arranging acute medical care at other clinics rather than as their sole provider of care. In some cases, the “Executive Health Program” would accommodate an acute illness in a dignitary or his/her spouse. In other instances, “Executive Health Programs” did little more than act as a liaison between the MTF’s primary care clinic, and the flight surgeon’s office. This created confusion for the patients in crisis. In many instances, these general officers that are rated, use the flight surgeon’s office as a default. This has its own implicating problems, least of all, loss of patient continuity of care, and

sometimes, incomplete medical records. If the flight surgeon is called upon to render the dignitary health care, the patient's expectation has become much higher in regard to accessibility and protocol, given their premier experiences in the controlled setting of the "Executive Health Clinic." This adds to the "hurried" state perceived by the flight surgeon that has fewer resources to obtain specialty consultative access and "instant" laboratory results. Even the pharmaceuticals are managed differently. When a dignitary is seen in "Executive Health Programs," it is usual practice to send a runner to the pharmacy to fetch the dignitary patient's prescription. However, if they are acutely ill and pay a visit to the MTF's primary care clinic or flight surgeon's office, the patient may, and does frequently ask, "Where do I go to get these drugs?" having not formerly been to the pharmacy themselves.

The "Executive Health Program's" evolution to an annual physical examination took on a life of its own. Since it was not formalized, local experience directed operating instructions. There are no standard procedures for just exactly what constitutes an Executive Health annual examination. Some MTF's would run a huge battery of laboratory tests: others, very few.⁴ Almost all of them performed an annual electrocardiogram (ECG) and lipid profiles. The latter became the hot topic for the author's patients. Cholesterol results predominated over nearly all else as the true exam's benefit. The greater issue was what to do with elevated blood lipids? In usual practice, an Algorithm is employed that constitutes a stepwise plan to reduce blood cholesterol through diet. But, herein lies another dilemma: Executive officers frequently have little control over their diets and exercise habits.⁵ The time demands upon them and the frequent, actually constant, social luncheons and dinners, with less-than-optimal meal

constituents, prevent the vast majority from ever gaining a true control over their dietary intake. Consequently, many are given directions and dietary plans to direct them toward healthier diets and exercise. The author saw perhaps one or two moderate successes out of a hundred. What these patients required was cholesterol-lowering medication. The author witnessed many accounts of the dignitary non-complying with medication regimes. The worst cases occurred where dignitaries sought refills of their medications from outside the original caretaker seen in the “Executive Health” Clinic. Whenever these other health care providers recognized that a conservative, stepwise approach to blood cholesterol had not been fully exploited, such as a low-fat diet, many would convince the dignitary that the medication was a last resort due to possible adverse side effects, then advised the patient (again) to adopt a healthy diet and discontinue the cholesterol-lower medication. When these patients were re-evaluated during their annual physical examination, the process would be re-instituted.

Returning to the issue of the perception that the dignitary officers developed over the healthcare system, it should be noted that the primary breakdown in communication and continuity of care, has its genesis in lack of a true, organized, sanctioned Executive Healthcare Program. If there had been sanction and Air Force-level direction of these “Executive Health Programs,” they would have been far more successful. But given that each program had its own character and operating procedures, there was no standardization, nor formal recognition.

The real crux of the matter is the false sense of security that an annual physical examination imparts to the executive patients.⁶ The patients are not experts in health care. In fact, the Executive healthcare providers are not even well acquainted with the

occupational hazards and workplaces of their own patients.⁷ This all adds up to a great deal of guessing from the health care provider's standpoint, and false promises on behalf of the patient. In the author's experience, many of the executive patients would tolerate symptoms of illness because they knew they could have them "fixed" during their one "big day" at the Executive Physical Examination date. A great deal of this irrational tolerance of underlying illness, whether it be a skin lesion that had rapidly changed, or the proverbial "indigestion" indicative of a possible cardiac problem, would hardly be tolerated by the average individual.

Medicine is not an exact science and the use of the word practice has its basis in the ongoing, burgeoning education that the physician experiences. On the other hand, modern American medicine has evolved to a level of scientific rigor such that we have recognized certain "standards of care."⁸ For example, if a 45-year-old male makes his way into the Emergency Department (ED) of a hospital complaining of chest pain, there is a standardized protocol that the medical practitioners must recognize and address. If, in this case, the physician makes a cursory examination and takes an abbreviated history, the patient may be either under or over diagnosed. In either case, the best remedy may not be rendered. In the worst case, the patient may be suffering from a myocardial infarction or ischemia ("heart attack") and the physician makes a diagnosis of "indigestion." Many case reports have surfaced in the literature whereby these patients were released with a bottle of antacids only to wind up dead from a heart attack.⁹

At the other end of the spectrum is the over conservative approach. In this case, taking the same patient, the physician cannot exclude the possibility of an underlying

heart condition masquerading as indigestion. These patients are subsequently hospitalized and undergo a fairly extensive evaluation at a premium cost.

In either case, the physician practitioner needs to follow the current “standard of care” for his/her specific geographical setting, technical support, and clinical evidence. It cannot be overemphasized that these so-called “rules” or “standards of care” are not documented in any one particular book or journal. The practitioner must stay abreast of current diagnostics and therapeutics and must pursue his/her highest level of clinical acumen throughout their careers. It is generally during peer reviews, either randomly selected treatment cases, or adverse therapeutic outcomes that adequacy of treatment becomes critical. In the aforementioned example of the patient complaining of chest pain and dying of a heart attack, due to improper diagnosis (i.e., “indigestion”), that physician would most likely be accused by his peers as not having met the standard of care and, therefore, subject to both medical institutional punishment and legal malpractice as well. In the second example, if the patient was urgently hospitalized and the appropriate tests administered, even if the patient had indigestion and no underlying heart condition, the physician could hardly be criticized. Therefore, it is generally much safer to practice conservative medicine and perform extensive testing to avoid missing, even, an unlikely event. These are some of the variables that comprise the acceptable “standards of care.”

Impact on the Executive Patient

As has been briefly described, medicine follows fairly standardized protocols for patient treatment. Take, for example, during a routine health encounter for symptoms suggestive of a common “cold,” the patient fills out a questionnaire including allergies, medications, and some description of the current illness and some biographical

information. Then he/she receives some sort of vital signs screening, most commonly, body temperature, pulse rate, and blood pressure. The patient then awaits the physician's examination. The physician habitually reviews the patient's vital signs, ascertains more detailed information, then performs some sort of physical examination. This may additionally require laboratory blood work or radiographic imaging, (for example, x-rays) and eventually the physician discusses the most likely diagnosis, treatment, and prognosis. The physician then may write a prescription and explain to the patient what the intent of the medication is, instructions on how frequently and how much to take, and for how long. This is a very common, day-in-day-out routine for a practicing physician. This is so routine, in fact, that to deviate from this system of "assembly-line" health-care administration, frequently leads to either an incomplete assessment of the patient, or a cascade of untoward events that can result in an unfavorable outcome. In the author's opinion, this failure to follow mundane routines that actually have proven value is one of the primary factors that antagonize every executive healthcare encounter. The common perception being that the executive has no time to waste on "unnecessary" or "common man" tests. This inevitably leads to less than optimum health care.¹⁰

Notes

¹ John R. Mace, Executive Director, Executive Health Program, Ramstein AB, Germany, Telephonic Interview, September, 1997.

² Ibid

³ Ibid

⁴ Ibid

⁵ P. Goldberg, *Executive Health*, (McGraw-Hill Publications, 1979): 62-71.

⁶ Barry Gilbert, *Management Magazine*, "The Myths and Realities of Executive Health," (August 1993): 7:8-10.

⁷ Dr. (LTC, USAF) Peter M. Demitry, Resident, Occupational Medicine, Harvard School of Medicine, Telephonic Interview, November 1997.

⁸ *Guide to Clinical Preventive Services*, 2nd Ed: "Report of the U.S. Preventive Services Task Force 1996," n.p. International Medical Publishing, Inc., Alexandria, VA.

Notes

⁹ Barry Gilbert, *Management Magazine*, “The Myths and Realities of Executive Health,” (August 1993): 7:8-10.

¹⁰ Ibid

Chapter 4

Case of a Lieutenant General

To illustrate the point of capriciously departing from standardized health care administration, let's review a factual case. It involves a 57-year-old male, USAF Lieutenant General. The General had been experiencing difficulty urinating for many months. Too busy to make an appointment to consult a physician, he decided to defer help until his Annual Executive Physical Exam. He appeared early on the morning of his scheduled annual examination. Because of his stature and prominence, a newly appointed hospital commander decided that he would conduct the physical examination, thus usurping the duties of the assigned and experienced Executive Health physician. The General was greeted by protocol and did fill out the appropriate medical history forms. The commander-physician stood by anxiously awaiting his debut with the General officer. In fact, so much so that he curtailed some portions of the screening-in process because he was both anxious to please the General and because he was unfamiliar with the Executive Health Care procedures and didn't really appreciate the value of what may have appeared to him as inefficiency.¹ In any case, the general was taken into the commander-physician's office and the formal examination began. In the course of the examination, the General mentioned that he was disturbed by his inability to completely void his bladder during urination. The commander-physician, a sub-specialist not in

primary care, quickly ushered the patient to the hospital's urologist. The urologist was caught by surprise because he was told that the General would be seen by him one hour later than when he arrived. It is unclear as to exactly what occurred during the urologist's examination. The commander-physician stood nearby over the urologist in order to coerce him to expedite his evaluation. The urologist wrote out a prescription that was picked up by a technician and handed to the General in a brown sack at his departure.

Three months later, the same general walked into the author's flight surgeon clinic seeking help for his urination problem, stating "the drugs ain't working!" The General was seen by a very competent Captain flight surgeon. This flight surgeon immediately performed a rectal-digital exam to assess the patient's prostate. The General complained how uncomfortable "the finger in the rectum thing" was. However, the young flight surgeon told the General point blank that he felt an abnormality on his prostate and was going to refer him to a local urologist. The General was confused and asked why he needed to see another urologist. He had just seen one. The flight surgeon could find nothing in the General's medical records referring to either the previous urologist's evaluation or the Executive Physical Examination. The young flight surgeon maintained his integrity and did the proper thing. He realized that something was amiss. The flight surgeon drove the General to a waiting urologist at a nearby hospital within minutes. A thorough examination was conducted. The ultimate diagnosis was advanced prostate cancer.

But the worst was yet to come. After biopsies had been taken and the diagnosis was confirmed, the patient (General) was informed that he would require a radical prostatectomy with an orchiectomy. The General, lying in his hospital bed facing two

physicians in long white lab coats, asked what this meant in laymen's terms. One of the physicians explained that they were going to "cut out his prostate and castrate" him. The General was speechless and by his (the General's) own account "laid there paralyzed as the two men just turned around and left the room." The patient called his wife to attend him. He relayed this dismal plan to his wife, who was more able to approach the physicians because she was possibly less intimidating to them. Apparently they took much more time to explain the diagnosis, treatment, and outcome to her than to the patient himself. She returned to her panic-stricken husband to discuss the therapy. He was significantly relieved to discover that the castration was a surgical removal of his testicles. The General had interpreted it as removing his penis!

Case Discussion

This is an eloquent example of the "VIP SYMDROME."² It "turned course" from the beginning of the patient's own symptoms and his misbelief that he could postpone medical intervention until his "magical" annual exam. A sense instilled into him by the medical institution itself. The very "Executive Health Program" actually misleads the patient into believing that a one-time annual, good "going over" is the right medical approach.³ It is almost standard verbiage to wish the departing Executive a good year and an expectation "to see you next year." One can see how ambivalent this sort of message imparts to the patient. The other factor resides in many Executive's own minds—that is, that they are invincible to catastrophic illness.

The last minute "change of guards" at the Executive Health facility, i.e., the commander usurping the seasoned Executive physician, was not only unfortunate for the patient, but borders on medical impropriety. It is reasonable, from the author's

viewpoint, that the commander didn't anticipate any serious illness in the General and believed the self benefit of "face time" with the General would outweigh any medical condition lying outside his capability to properly address. Because this physician was now an administrator, his clinical skills were not proficient. Additionally, his specialty was not in the area of General Practice, which is exactly what is appropriate for this type of screening examination. When the issue of urinary symptoms arose during the commander-physician's examination, it interrupted the examination abruptly and created a false urgency that was passed on to the consulting urologist. The urologist, in turn, was caught off-guard and under the anxious scrutiny of his boss, the commander. This resulted in what practitioners refer to as a "hit and run" medical encounter. As far as the author was able to ascertain from conversations with the involved individuals, it is doubtful that the General ever received a rectal prostate exam during this entire furious effort! This is tantamount to a soldier going into battle without bullets.

When the General had no alleviation of his symptoms, after three months of taking a medication prescribed for non-cancerous enlarged prostates, (Benign Prostatic Hypertrophy), he regressed to his old "pilot" days. The days of past when you could just walk into the flight surgeon's office and get good, old-fashioned medical care. Following his intuition he did indeed make an unscheduled walk-in to the flight surgeon's office. All the appropriate medical procedures were instituted without shortcuts or panic. The very competent Captain flight surgeon exercised standard medical care and discovered the cancerous nodule on the patient's prostate. Further, this young doctor recognized that the patient was being treated in a non-standard fashion when the patient's medical records were void of any evidence of previous medical intervention. This was in large

due to two factors: The first is that the Executive Health Care facility always dictated, typed, and compiled a narrative summary for every executive. This took days to weeks to accomplish. Secondly, a busy commander, practicing medicine infrequently, may be very slow to “feed” such a bureaucratic process with the time needed to dictate a summary of the healthcare encounter.⁴

When the patient was delivered to the local urologist at a nearby hospital, he received appropriate technical care. The missing element was “bed-side manner.” The physicians caring for him were no doubt anxious of his “celebrity” status and failed to afford him the same comforting words they would an ordinary patient. In the patient’s own words he related that he “was in the dark and scared.” When the two urologists came into his room and stood “ a good six feet away from” the patient, they blurted out the medical “jargon” and turned around and walked out. This left the patient feeling that because he was a General officer, the perception was that he just wanted the bare facts without the fluff. This is far from true. The executive patient has the same emotional needs as everyone and needs courageous, patient-centered, sensitive medical care.⁵

Notes

¹ John R. Mace, Executive Director, Executive Health Program, Ramstein AB, Germany, Telephonic Interview, September 1997.

² J. A. Block, “Beware of the VIP Syndrome”, *Chest* (October 1993): 104 (4): 989.

³ Barry Gilbert, “The Myths and Realities of Executive Health, *Management Magazine* (August 1993): 7:8-10.

⁴ John R. Mace, Executive Director, Executive Health Program, Ramstein AB, Germany, Telephonic Interview, September 1997.

⁵ Mark S. Smith and Robert Shesser, “The Emergency Care of the VIP Patient,” *The New England Journal of Medicine*, (November 1988): 319 (21): 1421-1423.

Chapter 5

Case of a General's Spouse

A 55-year-old four-star General's wife attended her husband for their Annual Executive Health Exam. Protocol was uncomplicated and neither the General nor his wife appeared hurried or demanding. The patients filled out the appropriate forms detailing their illnesses during the previous year and answered the standardized questionnaire designed by this program's administrator. Mrs. "General" notated in her questionnaire that she had been experiencing vaginal bleeding. It was the custom of this Program to refer any gynecological problems to the local referral hospital to be seen by a certified gynecologist.¹

The Executive Health physician, in this case, was new to the program. He determined that such a referral was unnecessary because he felt comfortable in General Practice and truly believed that he could adequately treat Mrs. "General's" vaginal bleeding. The General and his wife were given the "standard" treatment and wished well by the Executive Health's staff and sent a letter that they both had "a clean bill of health." Within the year, Mrs. General was dead. The cause of death was a malignant uterine tumor. The bleeding she reported was the sine quo non of such a condition.² Retrospectively, it was postulated that had she been properly diagnosed at the time of the

Executive medical exam, it “probably” wouldn’t have made any difference in her fatal outcome.

Case Discussion

The author was part of a peer review committee that investigated the foregoing case. It appeared, to the author, that at the time of this event, the Executive Health physician was a personal friend of the chief gynecologist at the nearby referral hospital. The chief gynecologist too was fairly new in his position. Because the peer review committee required an unbiased expert review by a certified gynecologist, it was coincidental that the reviewing authority was the chief gynecologist at the referring facility. His opinion was that the “standard of care” was met in this case. The author was surprised that this could be accurate, so he consulted a gynecologist geographically removed from this area. The author’s expert gynecologist was adamant that a uterine biopsy was “automatic” in the case of a post-menopausal female experiencing vaginal bleeding. The author was unable to alter the peer review panel’s conclusion that the standard of care was indeed met, due to the prestigious opinion of the first gynecologist. The author later determined that one or two salient biases may have influenced the Executive Health Care physician from referring this lady to the aforementioned gynecologist or his department. One, is that their friendship may have placed the “Executive Health” physician into a dilemma that would negatively influence his friend’s opinion of his own abilities. In this case, a very competent General or Family Practitioner could quite easily perform a uterine biopsy in the office. Why this physician did not remains unknown to the author. Nonetheless, the Executive physician either couldn’t perform the procedure or didn’t for whatever cause. Second, the “Executive Health” physician, new to the job, was feeling

the resistance from referral consultative physicians. These consultative physicians resented the VIP intrusion that disrupted their already busy routine. This produced a well-known animosity between the “Executive Health Program Clinic” and the nearby sister-service hospital. There was already some sister-service rivalry pre-existent to the “Executive Health Program’s” installation. There had been instances where a VIP “had to wait in line” when referred to a specialist at this hospital. The author believes that this friction biased the Executive Health physician from referring VIP patients if he could avoid it. If this were true, it would be a prescription for disaster.

Notes

¹ John R. Mace, Executive Director, Executive Health Program, Ramstein AB, Germany, Telephonic Interview, September 1997.

² *Guide to Clinical Preventive Services*, 2nd Ed, “Report of the U.S. Preventive Services Task Force 1996,” n.p., International Medical Publish, Inc., Alexandria, Virginia.

Chapter 6

Endeavors of the Executive Health Programs

As has been alluded, the USAF's "Executive Health Programs" were well-intended endeavors to provide flag-ranking executives and their eligible spouses "special" health care. The greatest downfall to these programs has been their rather rogue and unsanctioned operations. This in turn has led to many unrealistic expectations upon the patients that they served. It cannot be over emphasized that these annual "physical exams" led patients to a false sense of security.¹ A "clean bill of health," from what the patients perceived as "premium" healthcare, did little more than measure only a few parameters of medical well being. A battery of laboratory tests, at the discretion of the Executive Healthcare physicians, and sometimes by the technicians themselves, is not a detailed, "bullet-proof" examination. As an example, a routine electrocardiogram (ECG) during a scheduled physical exam, is of no value. An ECG is a diagnostic tool whose place is in monitoring the status of a patient during, or after, some significant cardiac event.² It is the author's opinion that a "normal" ECG is interpreted by the patient as having no heart problem. In point of fact, an ECG can be entirely normal in a patient with severe cardiac disease from coronary artery disease.³ There are more aggressive and detailed tests to assess the presence or absence of underlying coronary heart disease. But these are seldom performed unless the patient complains of heart-related symptoms. It is

further alarming that 50 percent of heart attacks have no preceding symptoms!⁴ Thus, it is unfair to allow, or cause, the executive patient to falsely believe that they are uncategorically well. This might suggest, then, that these examinations may do more harm than good.

What is it, then, that the executive needs from the healthcare community? First, both the patient and the caregiver must clearly understand the capabilities and limitations of one another. Every practicing physician should understand their patient's lifestyle and work habitat. Although this is formally recognized as the purview of the occupational medicine specialty, it is indeed incumbent that the primary caretaker undertake the effort to see what his patients actually do to their bodies, both on and off the job. This vital information can then direct the practitioner to take a more targeted approach to both health screening and, in the case of illness, diagnostic information. In researching this paper, the author spoke with an Occupational Medicine Physician in-residence. This individual was unaware of any Executive environmental exposure, and risk assessment at the Harvard School of Medicine, Occupational Medicine residency. The author discovered that Executive medicine is not even discussed (at least at this institution's program). Further, the interviewee had never heard the phrase, "The VIP Syndrome."⁵

This is some confirmation that a gap exists in the medical acumen of Executive Health Care. The most glaring question arising then, is such a thing needed? The author contends, yes.

A Look at the USAF General Officer

Before any program is designed, it should be determined if it is of significant value to those it serves. Next, in the case of a stand-alone Executive Healthcare Program for

USAF general officers, do the generals deserve “special” medical treatment? Do their spouses, and if so, why? What would such a program offer and what would it actually execute as a measurable product?

The author made numerous observations of the lifestyle of several general officers both socially, in their environment, and the clinical setting. This privilege was granted by virtue of being a four-star general’s personal physician and attaining a very close personal relationship with him. The foregoing are some observations made over a three-year period of time. First, it was noted that general officers have no daily schedule. Their responsibilities and demands provide constant stimulation. The normal duty day for a general officer is 24 hours long. Even when at home, their telephones ring constantly. If they are deployed overseas, there is little consideration given to significant time zone differences. If there’s something “hot” in the Pentagon at 6 o’clock at night, it’s hot for the general officer at 1 a.m. in the morning. General officers are responsible for people, places, and events far removed from their direct supervision. They are held to a very high standard of responsibility at all times.

During the workday, many meetings must be attended. There are many luncheons offering what would hardly constitute a healthy diet. Although it is touted by many Executive Health authorities that it is possible for the general officer to control his schedule, the reality prevents it.⁶ In order to exercise, the general officer usually finds time very early in the morning. (One general officer faithfully ran at 4:30 a.m. daily). The degree of discipline is humanly out of reach, given long duty days and interrupting phone calls throughout the night.

General officers travel extensively. It was not uncommon for a four-star general to travel from overseas to CONUS at least once every two weeks. The chronic jet lag seems well tolerated, but any clinician knows empirically that this is an inordinate stressor, both physically and psychologically.

It was observed that many general officers sought acute medical advice late in the afternoon or evening, given that it was their earliest opportunity to put self before duty. In these instances, many or most clinical outpatient services were closed and offered only emergency room treatment. The latter is a poor substitute for thorough medical care, and then there is the issue of follow-up. Nearly every emergency room encounter ends with a recommendation to “follow up with your doctor.”⁷ For the busy executive general officer, this is not a convenient option and easily disregarded due to other pressing matters. Again, many of these will “follow up,” so to speak, at their Annual Executive Health exam, sometimes months later. In these cases, it was miraculous if a written document even found its way to the patient’s medical record.

The average airman sees only the “special treatment” given to these general officers. This is frequently resented by “the troops,” but they actually have no perspective of their “snap shot” perception of the general officer’s lifestyle. An example is a personal staff car speeding out to the flight line to board a plane. The aircrew is usually standing by hours in advance, especially if they’ve been told to expect an earlier-than-scheduled departure. The general officer boards the plane and is whisked away in the most expedient manner. The general officer’s baggage transparently moves from the staff car to the plane by “escorts.” In the bigger scheme, that same general officer has no personal desire to rush down to the flight line, and his timing is not a matter of his convenience.

He is rushed, hurried, and pressured and probably very fatigued. He might need to compose a speech on the flight or pour over numerous papers that he must fully comprehend. The author, while attending some of these flights, cannot recall a single general officer sleeping during a flight with the exception of a few hours while on a transcontinental trip. On these flights they are frequently provided a meal, but not by their design. Just as at an official or social function, the food preparer's goal was to make the General "happy." Some know the General's food or beverage preferences from experience. The underlying theme, though, is that the food prepared is very tasty, given the amount of fat, salt, and sugar gone into them. This is the mindset of the food providers. "Make it taste and look good." In too many instances, the food served to general officers, outside of their own homes, is a function of the staff's effort to please the dignitary. The author deduced that in some of these large, fatty meals, a small bag of potato chips, a candy bar, and a Coca-Cola would be less damaging to their health.

The general officer's spouse is also a special case. They too appear to the average community as powerful, under control, and living quite a luxurious life. This would be the exception. The expectations of the spouses are tremendous. What is even worse is that many of their expectations are unknown to them! There is no guide or training program for them (save e.g. Capstone). In order to attempt to be a leader among the other spouses, the general officer's spouse must make speeches, club or organizational decisions, and attend multiple social and service-related functions, both with and without their general officer spouse's attendance. Because of their perceived power, or what is commonly called "pillow talk," they are inundated with spouses whose ulterior motive is to win favoritism for their husband's career. Therefore, the general officer's spouse must

remain constantly guarded over what she says, wears, or does. She too is constantly in the limelight. Both the general officer and his spouse find themselves in a small enclave of people like themselves. True friendship is never certain because ulterior motives abound. The stress imposed on the spouse, both externally, and from her role as a supporter to her husband has a large psychological impact. This psychological stress is usually kept to the patient, because it is newsworthy if a general officer or his spouse should suffer depression. Whereas in the civilian sector, an Executive officer's spouse may seek psychological help from a disinterested friend, or a private, confidential psychologist.⁸ The general officer's spouse does not have this luxury, especially overseas. Further, in the author's opinion, it is really the psychological stress, manifested by anxiety, paranoia, and depression that strikes most general officers and their spouses. But unlike the lesser grade airmen and families, they must "cope" with this because of the stigma associated with a visit to the mental health clinic. The author treated numerous depressed wives. There was tremendous resistance during therapy. First, the author would have to act as the mental health specialist, under the auspices of primary care conducted in the Executive Health clinic. The worst fear these spouses had was the inextricable fear that someone would "find out" they were depressed. Once this was conquered, the issue of antidepressant medication became the contentious issue. "Somebody in the pharmacy will leak the news." If we could overcome this issue, then it was in every case, except one, that the author would take the prescription to the chief pharmacist and have it filled. All refills were also obtained by the author.

Even though spousal personal relationships were a common denominator in these spouses' depression, no formal psychological counseling could be arranged between the

clinician, spouse, and general officer. In fact, there was usually a great deal of denial and resentment from the general officer to his spouse for “letting it out.” He too feared the public perception and probably a sense of denial because of his inability to prevent such a “collapse.” None of these cases ever leaked to the public. In fact, in one case, the author successfully treated a general officer’s spouse, which in turn “made it all right to seek help” after she, herself, shared the experience with a trusted friend within the enclave. That person then agreed to treatment for depression. In no case did the author treat a general officer for depression or anxiety. Their levels of ego defense, and largely their inherent ability to sustain the suffering, precluded such treatment. The issue of mental health, in the active duty military, in general, is a contentious subject. Most members fear the consequences of seeking psychological consultation from the Mental Health Clinic. Rated aviators are especially threatened by anything that even remotely suggests they have a “mental problem.” General officers are even more guarded about their emotional and psychological status. The latter could possibly benefit even more from psychological services than the average airman. This, in the author’s opinion, stems from their fear of loss of power or even the perception that they are not super strong, emotionally. Additionally, they seldom possess the same mundane network of average individuals whom they could easily confide their emotional troubles. If it is indeed largely mental prowess that makes an Executive officer what he or she is, then their mental and emotional well being might be more important than their physical health. Yet, because of the stigma and negative perception associated with seeking counsel with a mental health provider, herein lies a great problem. This problem does have solutions. One option would be for the Executive officer to seek psychological help in the private

setting. But, this would be an out-of-pocket expense. Another option would be to destigmatize the mental health myth. Make it all right to see a psychologist or psychiatrist.

The latter approach would have to include “buy-in” from the Chief-of-Staff of the Air Force. Additionally, resources would have to be provided for any additional medical/psychological services. The most convenient method of consultation would be in an Executive Health Program office. In this setting, it would be inapparent that the patient was seeking psychological services, per se. But it cannot be overemphasized that if the taboo of psychological assistance is not obliterated, there will be no impact on any endeavor to provide psychological assistance to general officers and their spouses.

Notes

¹ Barry Gilbert, “The Myths and Realities of Executive Health,” *Management Magazine*, (August 1993): 7:8-10.

² *Guide to Clinical Preventive Services*, 2nd Ed, “Report of the U.S. Preventive Services Task Force 1996,” International Medical Publishing, Inc., Alexandria, Virginia, n.p.

³ H. C. Sox, Jr. , A. M. Garber, and B. Littenberg, “The Resting Electrocardiogram as a Screening Test: A Clinical Analysis,” *Annals of Internal Medicine* (1989): 111: 489-502.

⁴ Ibid

⁵ Dr. (LTC, USAF) Peter M. Demitry, Resident, Occupational Medicine, Harvard School of Medicine, Telephonic Interview, November 1997.

⁶ Walter Weintraub, “The VIP Syndrome: A Clinical Study in Hospital Psychiatry,” *Journal Nervous Mental Disorders*, (1964): 138:181-193.

⁷ Douglas Diekema, “The Preferential Treatment of VIPs in the Emergency Department,” *American Journal of Emergency Medicine*, (March 1996): 14 (2); 226-229.

⁸ E.H. Feur and S. R. Karuso, “A Star-Struck Service: Impact of the Admission of a Celebrity to an Inpatient Unit,” *The Journal of Clinical Psychiatry*, (1978): 39: 743-746.

Notes

Chapter 7

Presidents' Health Care Cases

Earlier in this paper, we saw the epitome of the “VIP Syndrome” in the case of President Lincoln.¹ How far have we come in treating emergencies of Presidents in the last 130 years?

It seems unfair to criticize medical care provided to some past presidents since the medicine and surgery of their time were not as sophisticated as they are today. Even so, some former presidents did not received care appropriate to their day. In addition, the public was rarely truthfully informed and often deliberately misled.²

The gunshot wound that President Garfield suffered was ultimately fatal, but, he did not die as a direct result of his wound. He died of infectious complications from a false passage created in the liver in search of the bullet, 11 weeks later.³

In 1893, President Cleveland had a tumor, (cancerous), develop in the roof of his mouth involving the bony palate. He was secretly operated upon on board a yacht at sea near Buzzard's Bay, Massachusetts.⁴ This unorthodox action was taken for political reasons alone. The public was not informed. The lesion was said to be an epithelioma or a myxosarcoma. That he lived for 15 years brings into question whether or not the lesion was a malignant neoplasm. Review of the tissue in March, 1980, established a diagnosis of verrucous carcinoma. This tissue and institution were The, then and now, Armed

Forces Institute of Pathology. The surgery that had been performed aboard the private yacht by Dr. (Major) Robert O'Reilly was more radical than necessary, removing 2 ½ inches of his left maxilla. This was an unfortunate episode in which political considerations subverted both the president and his doctors.

President Wilson had a long history of cerebrovascular disease. His doctor served in a social and advisory capacity and was said to have been incompetent. Wilson's mental capacity was irreparably diminished from a stroke. The public was never informed.⁵

President Harding died of a myocardial infarction (heart attack) at age 57 years. His death was reported to be caused by food poisoning.⁶

President Franklin D. Roosevelt was seriously ill with hypertension and arteriosclerioses with symptoms of cardiac angina at the time of his fourth presidential election. His physician and a consultant refused to recognize this. He died of complications three months after his inauguration. No autopsy was performed and the public was unaware of the seriousness of his illness. Even the vice president was unaware of Roosevelt's medical condition and it was 20 years before the details were released in the *Annals of Internal Medicine*.⁷

President Eisenhower, during his term in office, had a heart attack and intestinal obstruction from granulomatous colitis, for which an intestinal operation was performed. This was the first time the health problems of a president were reported to the media and the public. Eisenhower died of cardiac disease several years after leaving office.⁸

Discussion

A President's health is of monumental political significance. The fallout that occurs when a president is impaired even prior to election, can spell doom for the office of the

presidency. The public is nervous of a leader that is less than in optimal condition to lead the country.⁹ This is of no small consequences to the international community that looks to the American presidency as the agenda-setter for world political events. Thus, it is not at all surprising that the President's health is of National Security importance. One can see, then, why clandestine medical care could avert lengthy explanations to an anxious public and provide a convenient covert medical encounter that might easily be substandard .

Notes

¹ G. J. Flattman and P. J. O'Leary, "Lincoln's Last Hours, *The American Surgeon*, (June 1997): 63, 561-56.

² "Being Called to Care for the Mighty Poses Unique Challenge for Attending Physicians," *JAMA* (July 1992): 270 (3), 298-301.

³ Oliver Beahrs, "The Medical History of President Ronald Reagan," *Journal of the American College of Surgeons*, (January 1994): 178:86-97.

⁴ S. H. Aziz, "The Oral Surgical Operations of Grover Cleveland: A Presidential Cover-up," *Journal of Oral Maxillofacial Surgery*, (1995): 53: 1088-1090.

⁵ Oliver Beahrs, "The Medical History of President Ronald Reagan," *Journal of the American College of Surgeons*, (January 1994): 178:86-97.

⁶ Walter Weintraub, "The VIP Syndrome: A Clinical Study in Hospital Psychiatry, *Journal Nervous Mental Disorders*, (1964): 138:181-193.

⁷ H. G. Bruenn, "Clinical Notes on the Illness and Death of President Franklin D. Roosevelt," *Annals of Internal Medicine*, (1970): 72:579-591.

⁸ Oliver Beahrs, "The Medical History of President Ronald Reagan," *Journal of the American College of Surgeons*, (January 1994): 178:86-97.

⁹ Ibid

Chapter 8

President Reagan's Health Care

Of all the American presidents, Ronald Reagan stands out as a man honest and open to the public regarding his health. His openness and “easy-going” manner may have contributed to his survival following the assassination attempt in 1981.¹

On March 30, 1981, three months after becoming president, Reagan was struck by a would-be assassin's bullet. The president had just left the VIP entrance of the Washington Hilton Hotel after giving a talk. As he walked toward his limousine, shots rang out. A White House secret agent pushed him into the car and then threw his body over the president to protect him. It was first thought the president had not been hit, but he then experienced severe chest pain, possibly due to the trauma of falling on the transmission riser as the secret agent fell on him for protection. The limo sped off toward the White House, some ten minutes away.²

Enroute, Reagan complained of difficulty breathing and coughed-up blood. Secret agents redirected the limo to George Washington University Hospital (GWUH) close-by. On arrival, the president walked about 45 feet into the building, and gasping for air, collapsed to one knee. He was placed on a gurney (stretcher) and taken to the Emergency Room (ER). When seen in the trauma room by Dr. Joseph Giordano of the trauma team,

Reagan was considered to be in acute distress. At this time, the president's personal physician was at his side in the hospital and remained there until his release.³

During the initial examination, there was no external evidence of a bullet entry, but blood was noted in his mouth and around his teeth. He complained of left chest pain and was pale and dyspneic, (short of breath). Upon removal of his clothing, a few drops of blood were seen on his shirt. There was a clean wound slightly larger than one centimeter in diameter at the fourth interspace in the left posterior axillary line, (side of the chest). Auscultation, (listening to breath sounds through a stethoscope), of the chest revealed decreased breath sounds in the left lung cavity. Oxygen was administered. A chest x-ray revealed a hazy left hemothorax, (blood in the left lung cavity), and a metal fragment in the left lower chest. Intravenous (IV) fluids were started, an arterial line inserted, and a Foley catheter was placed in the urinary bladder. Even a tetanus toxoid shot was given at this time. Dr. Giordano inserted a chest tube into the left lung cavity to drain the blood. Considerable blood escaped through the tube into the collection bag.

Blood transfusions began while doctors debated the best course of action. After consultation with a cardiothoracic surgeon, it was decided to take Reagan to surgery. Since the bullet, which was thought to be a .38 caliber, was too small as seen on x-ray, it was prudently decided to perform a peritoneal lavage to rule out intra-abdominal injury. This is a procedure where a needle is inserted into the abdominal cavity and a liter of sterile saline is poured into the abdomen. If the fluid is then withdrawn without any blood, it is a good sign that there is no abdominal injury from a passing bullet. Indeed, the peritoneal lavage was without blood.

Surgeons opened Reagan's left chest and began exploring for the bullet. With some difficulty, the flattened "dime-sized" bullet was found and extracted. It was found one-inch from his heart. It was later determined that the missile was a .22 caliber bullet known as a "lead azide devastator" which had flattened when striking the limousine behind the right door before entering the President's chest.

The president received intravenous antibiotics and was moved to Intensive Care. When Reagan, within six hours, showed significant improvement and stability, his doctors decided to move him to a private suite. The president spent 13 days at the GWUH. This was unprecedented. Many authorities urged the President to consent to moving him to a military hospital. The President refused. He contended that he was extremely pleased with his care at GWUH.⁴

Analysis

Several factors were responsible for Reagan's favorable outcome of the assassination attempt. First, when the secret agent saw blood coming from Reagan's mouth, he redirected the limo to the nearest hospital, which was George Washington University Hospital. Second, Dr. Girodano and other personnel immediately initiated resuscitation procedures in the Emergency Room, "by the book!"⁵ Third, his doctors did not hesitate to take him to surgery. Fourth, Nancy Reagan, under a very stressful event, gave support to her husband and in no way interfered with his medical care.

President Reagan escaped the "VIP Syndrome." Competent individuals performed their duties in every detail, just as they would for the average patient. No shortcuts were taken nor were any non-standard medical protocols engaged. It was said that the President's own personality kept everyone at ease with his quips. He said to the nurses

after the endotracheal tube was removed, “I’d like to shoot this scene over—starting at the hotel.” He asked how long it would take to recover, and the nurses told him 10-14 days. He said he was a fast healer, and a nurse told him to keep up the tradition. Reagan replied, “you mean this may happen several more times?” A little later he quipped, “I wonder what this guy’s beef was. He must have gotten off three or four rounds.” (Actually, the gunman had fired six rounds.)⁶

The hospital arranged for a command post and secret service agents to remain during Reagan’s stay. The working relationship was so carefully planned and executed, that there was little or no interference with either President Reagan’s care nor the other patients and medical personnel. The President’s personal physician was always around but never intrusive. One of the attendant physicians commented after Reagan’s release that the President himself contributed to the quality of his own care. “He was very much in command, but not in the way you might expect. It was through his sense of humor-his jokes and one-liners, that he commanded good medical care by relaxing people and letting them be themselves.” The doctor went on to say, “There’s a medical lesson to be learned from all of this: ‘Beware of VIP treatment!’”⁷

Notes

¹ All the President’s Doctors, *Medical World News* (April 1981): 9-20.

² Oliver Beahrs, “The Medical History of President Ronald Reagan,” *Journal of the American College of Surgeons*, (January 1994): 178:86-97.

³ Ibid.

⁴ Ibid; All the President’s Doctors, *Medical World News* (April 1981): 9-20.

⁵ Mark S. Smith and Robert Shesser, “The Emergency Care of the VIP Patient,” *The New England Journal of Medicine* (November 1988): 319 (21): 1421-1423.

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⁷ Ibid

Notes

Chapter 9

Executive Health Programs In the Civilian Sector

In the late 1970s, the trend toward preventive medicine had made annual physical examinations in most large corporations almost standard policy.¹ However, even at that time many experts questioned their cost effectiveness. The proponent of annual “CEO” exams were aimed at identifying the big “silent killers,” e.g., coronary heart disease, high blood pressure, and cancer. The advances in medical diagnostic technology, enabled the early detection of these disease with the hope of early intervention.²

In the late 1970s, IBM claimed that one-third of its employee exams turned up medical problems that the subject had been unaware of.³ But critics of these so-called success stories point up that these exams are not worth the cost. In most diseases, the argument goes, treatment is not practical before symptoms arise.⁴ A Harvard endocrinologist opposing annual executive exams contends that the annual physical examination is of little value and nothing more than an elaborate and expensive ritual.⁵

A seven-year study at Kaiser-Permanente’s pre-paid health plan, wherein 5,000 people were urged to have annual examinations, while another group was not, showed no appreciative differences in health status. The death rate among those annually examined was slightly lower than those not examined, but more of the annually-examined subjects were found to have more chronic illnesses.⁶

Throughout the 1980s and 1990s, “healthy lifestyles” of the executive workforce, promulgated by Health Promotion enthusiasts, spread to the blue-collar workforce. This, coupled with managed healthcare, resulted in prevention versus early detection of disease.⁷

By the 1990s, enough observational information became available to deduce that the dissemination of “Health Promotion” propaganda throughout the full structure of a workplace, was justifiable logistically as well as fiscally. It has been said that executives are not those at greatest risk of serious disease within their organizations.⁸ In point of fact, research indicates that socioeconomic status is the greatest reliable indicator of risk of serious disease, for example, heart disease.

As managed healthcare forged its way into American medicine in the 1980s, and into the present, justifying costly annual physical examinations for company executives became untenable.⁹ Evidence that the legacy of the many initiatives performed in the belief that companies were protecting their most-valued asset, the CEO, came under rigorous scrutiny. Managed healthcare contractors and Health Insurers became skeptical of the lavish annual CEO health assessments. This was the “wake-up” call to reassess the cost-benefit ratio of “shot-gun” medical screening of CEOs and their spouses. Information from the Canadian Task Force on risk assessment screening was accepted by the American medical community and company’s health insurers.¹⁰ This has led to a fairly standardized algorithm of appropriate medical screening dependent upon individual risk factors, rather than Executive-level status in the company.

A “cottage industry” has thus cropped up in the American medical community. A multitude of private practice Executive Health Programs pervade the country in

competition over providing annual health assessments of “business and professional leaders throughout the world.” These organizations are largely reimbursed by major health insurers, such as Pacific Health Care.¹¹ The cost of an individual annual examination ranges from \$500-\$1,000, dependent upon the individual’s risk assessment. For example, sigmoidoscopy to detect colon tumors, would only begin at age 55-60 years.¹² Cost-mindedness and fierce competition over this fairly new private practice initiative, i.e., Executive Health Programs, is driving costs per individual down because the number of unnecessary tests and procedures are minimized. Practitioners in Executive Health Programs are practicing within “safe” conservative boundaries that have been provided by the Preventative Medicine Task Forces that have written guidelines for what constitutes the “standard of care.” This is a safeguard against medical malpractice because it is “safe” to practice at least within these accepted guidelines, if not even more conservatively, i.e., perform more tests than are standard protocol.¹³

In order to provide readers a notion of the prestigiousness of Executive Health Program participants, a hand full of private-practice companies follows: The Mayo Clinic, Duke University, Scripps Memorial Hospitals, Johns Hopkins, and Scott and White Hospital Health Plan. The interested reader will find several Internet web sites that advertise Executive Health Programs. Of great interest is the emphasis on “maintaining healthy lifestyles.” The implication being that an individual subscribing to these services is already in good health. These institutions also emphasize that this is a “comprehensive health assessment,” and not a panacea for longevity, nonetheless, the

author perceives that many of these companies imply that an annual physical assessment is the premier standard of care for the “busy client.”

Notes

¹ Ann Beilig, Director, Executive Health Programs, Pacific Care, Telephonic Interview, February 1998.

² P. Goldberg, *Executive Health*, McGraw-Hill Publications (1979): 62-71.

³ Ibid.

⁴ *Guide to Clinical Preventive Services*, 2nd Ed. “Report of U.S. Preventive Services Task Force 1996,” International Medical Publishing, Inc., Alexandria, Virginia: n.p.

⁵ P. Goldberg, *Executive Health*, McGraw-Hill Publications (1979): 62-71.

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⁷ Barry Gilbert, “The Myths and Realities of Executive Health,” *Management Magazine* (August 1993): 7:8-10.

⁸ Ibid.

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¹⁰ *Guide to Clinical Preventive Services*, 2nd Ed. “Report of U.S. Preventive Services Task Force 1996,” International Medical Publishing, Inc., Alexandria, Virginia: n.p.

¹¹ Ann Beilig, Director, Executive Health Programs, Pacific Care, Telephonic Interview, February 1998.

¹² Ibid.

¹³ *Guide to Clinical Preventive Services*, 2nd Ed. “Report of U.S. Preventive Services Task Force 1996,” International Medical Publishing, Inc., Alexandria, Virginia: n.p.

Chapter 10

Should VIPs Receive “Special” Medical Care?

Many articles in medical literature point out that whenever practitioners deviate from standard medical protocol, they are in danger of “The VIP Syndrome.” This gets back to treating the Executive as you would anyone else. The disruption occurs whenever the Executive enters the health arena as anyone else would, for example, the emergency room. A well-known celebrity or a demanding, commandeering CEO is not likely to sit and wait for hours in order to be seen by a physician.¹ An additional observation is the admission of a VIP into an inpatient psychiatric unit.² The disruption here in this setting is reportedly catastrophic for the VIP, the medical staff, and the other patients. The greatest examples of medical blundering appear to occur when the VIP enters the medical treatment arena acutely ill and unexpectedly.³ This is where “politics” and good medicine seem to clash. Therefore, the issue of privileged medical care and annual examinations are more a matter of a patient’s health status than any other variable.

Regarding non-acutely ill encounters, the value of an annual or periodic medical check-up can still not be under-rated for very, very important persons. Take the case of President Bush. He received his annual “executive physical” and was given a clean bill of health. His physician followed “standard protocol” for a man Bush’s age and medical history. Per guidelines of the American College of Physicians, he omitted thyroid-

function testing. Shortly after his physical, Bush ordered the United States into the Gulf War, against the advice of some of his senior advisors. Only then did the onset of atrial fibrillation herald the presence of underlying hyperthyroidism.⁴

Since hyperthyroidism may promote impulsiveness, *New York Times*' physician columnist Laurence Altman wondered, editorially, whether what is cost-effective for an ordinary patient is similarly so for a president. Indeed, would earlier detection have altered presidential policy? The incremental cost of performing thyroid-function tests is small and commonplace in everyday practice.⁵

All of medicine involves the calculation of odds. But is the margin of tolerance for error the same for everyone? The author contends that military General Officers and senior diplomatic officials need, not necessarily deserve, special treatment. The importance of their health and its relationship to their work performance and competency is too important to the nation they serve.⁶ Risk-analysis and cost-effectiveness involves mathematical statistics and odds for the entire population.

In statistical predictions, one takes chances of missing some salient underlying medical condition that may not cause the VIP patient symptoms. But the implication of an underlying medical condition could have tremendous implications for all those the VIP serves. It is the author's position that one patient does not represent a statistical risk, for a single individual's risk of having a disease is either all or nothing. This being the case, it is the author's opinion that all Air Force, and military General Officers, require at least a comprehensive annual, if not semiannual, physical and psychological examination. Following this rationale, it is not a matter of deserving special care, which implies

receiving benefits deprived the general population, but reasonable investment that should promote a responsive, comprehensive Executive Health Program.

Such an Executive Health Program, whether provided by a DoD facility or a private institution, should dare to go beyond common everyday practice. It should, as a minimum, perform the tests recommended by the American College of Physicians.⁷ Further, it should “leave no stone unturned.” That is, a full and comprehensive cardiac work-up should be pursued as frequently as is necessary to rule out early coronary disease. This will, of course, lead to some false positive results from some studies, such as a stress treadmill test. These can be investigated further with more definitive tests, such as coronary catheterization if need be.

Further, cognitive and psychological testing should be a part of every VIP’s annual examination. This has not been common practice in the U.S. Air Force’s former Executive Health Programs.⁸ Such testing may arguably be more valuable than physical health determination, for it is actually mental functioning, rather than physical health status, that determines the effectiveness of a leader in the U.S. military.

Notes

¹ Mark S. Smith and Robert Sheeser, “The Emergency Care of the VIP Patient, *The New England Journal of Medicine* (November 1988): 319 (21): 1421-1423.

² E. H. Feur and S. R. Karuso, “A Star-Struck Service: Impact of the Admission of a Celebrity to an Inpatient Unit,” *The Journal of Clinical Psychiatry* (1978): 39: 743-746.

³ Robert E. Strange, “The VIP with Illness,” *Military Medicine* (1980): 473-475.

⁴ Philip R. Alper, “More on the President’s Checkup,” *The New England Journal of Medicine* (July 1995): 333 (24): 1645.

⁵ G. D. Rubenfeld, “Another Truly Presidential Checkup,” *The New England Journal of Medicine* (1995): (1):260.

⁶ Philip R. Alper, “More on the President’s Checkup,” *The New England Journal of Medicine* (July 1995): 333 (24): 1645, and G. D. Rubenfeld, “Another Truly Presidential Checkup,” *The New England Journal of Medicine* (1995): (1):260.

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⁷ *Guide to Clinical Preventive Services*. 2nd Ed., “Report of the U.S. Preventive Services Task Force 1996” International Medical Publishing, Inc., Alexandria, Virginia

⁸ *Guide to Clinical Preventive Services*. 2nd Ed., “Report of the U.S. Preventive Services Task Force 1996” International Medical Publishing, Inc., Alexandria, Virginia

Chapter 11

Conclusion

The health care of VIPs, both civilian and military, deserves some special consideration. The USAF, until recently, conducted programs tailored for General officers and their spouses. These so-called “Executive Health Programs” were never standardized within the USAF. The number and type of health services they provided varied from place-to-place and time-to-time. Eventually, the Air Force sought to close these programs in order to comply with DoD Directives preventing “special treatment” of any persons in DoD.

History has documented numerous cases of a pervasive medical problem come to be known as “The VIP Syndrome.” The entrance of a VIP or celebrity challenges the normal practices of physicians and their institutions. The result of treating VIPs differently than “common individuals” can sometimes be catastrophic. By not adhering to common practice guidelines, physicians risk compromising their basic powers of perception, judgement, and treatment. The “VIP Syndrome” is not well known in the medical community. This poses a risk to every health care institution encountering a VIP in a medical treatment setting.

Issues of VIP medicine become newsworthy whenever a VIP of the Executive branch of government becomes ill or injured. Nearly every detail of that VIPs medical

care is, open to close, arduously scrutinized. The case of Abraham Lincoln's assassination clearly exemplifies the "VIP Syndrome." Administrative "doctors" are not necessarily the most qualified clinicians, especially in the care of very ill patients.

The other extreme of treating life-threatening trauma involving VIPs is the day-to-day mundane task of assessing a VIP, presumably in good health. It has been customary to provide the VIP and his/her spouse with a very detailed annual physical examination. In the civilian sector, managed health care and constraining resources have cast questions over the cost-effectiveness of these comprehensive examinations. Managed healthcare and the acceptance of standard medical guidance, which is based upon statistical risk assessment, has decreased the number of unnecessary, expensive screening tests performed. This has not, until recently, been a focal problem for the USAF Medical Corps.

The value of a periodic health assessment to USAF General Officers should have a rational basis. Medical practicing guidelines should be followed. However, because of the power USAF "VIPs" represent, even a salient, asymptomatic illness can have significant consequences for the many people they serve and represent. The case of President Bush's hyperthyroidism and his decision to initiate the Gulf War, should lead us to consider the levity by which we determine whether a VIP is "granted" special medical care, or whether a VIP "should receive" special care.

It is the author's conclusion that USAF General Offices need comprehensive annual physical examinations that go above the norm in terms of meeting "the Standard of Care." Standardized medical care is based upon statistical analysis. Statistics do well to serve Public Health agencies and guide practitioners in providing good, standardized

medical care. The problem with this is that no one individual truly carries a risk probability; an individual's odds of having a medical disease are either all-or-none.

If the USAF is willing to expand resources ensuring personnel reliability security of weapons systems, then the analogous reasoning should be applied to its corporate, i.e., General Officer leadership. A salient medical condition, unscreened for by applying statistical medicine, can hardly be afforded.

Whether the USAF leadership supports an officially ordained "VIP Health Program," as described in this paper, should be a matter of further research and argument. The issue of "special privilege" needs to be separated from "by necessity." That VIP medicine is different and extraordinary from commonplace medicine must be evaluated by Air Force leadership. The author's experience suggests that the medical treatment and care of Air Force General officers is far from routine and standardized. The USAF should acknowledge this statement and commit resources to further research the value of a robust Executive Health Program.

Lastly, every healthcare provider should receive some form of awareness training regarding the treatment of VIPs and the "VIP Syndrome." The syndrome is real and potentially very disruptive to the USAF medical community and the General Officer VIPs it serves.

Glossary

Abbreviations:

CEO	Chief Executive Officer
CONUS	Continental United States
CPR	Cardio Pulmonary Resuscitation
ECG	Electro Cardiogram
FSO	Flight Surgeons Office
MTF	Military Treatment Facility
VIP	Very Important Person

Definitions:

Arteriosclerosis. Hardening of the arteries, usually caused by high blood pressure, leading to even higher blood pressure and decreased blood flow due to narrowing of the arterial lumen (inside diameter). It can affect literally every bodily artery

Atrial Fibrillation. An electrical abnormality of the heart's rhythm. Many causes including Hyperthyroidism (see Hyperthyroidism)

Auscultation. The act of listening to inner body functions, (e.g., breathing sounds) through a physician's stethoscope

Axillary Line. An imaginary line drawn from the armpit down the side of the chest

Benign Prostatic Hypertrophy. Non-cancerous enlargement of the male prostate gland usually associated with the aging process. Results in compressing the urine outflow tract

Canthus. That portion of the eye closest to the nose. The small bump in the corner of the eye where secretions gather.

Capstone. A formal two-week intensive course to indoctrinate newly selected General Officers and their spouses to the formalities and customs of General Officer rank

Cardiac Angina. Chest pain caused by inadequate blood flow to the heart muscle leading to pressure upon the chest and pain in the area of the heart which can spread to the neck and down the left arm

Catheterization. Usually performed on the heart's coronary arteries, it involves introducing a small thin plastic hose from outside the body, through a major artery and into the heart. A dye is injected and continuous x-rays are taken showing the flow or lack thereof in the coronary arteries

Cerebrovascular Disease. Narrowing of the arteries feeding the brain. Can result in decreased blood flow to the brain and blockage (causing a stroke)

Coronary Heart Disease. Narrowing of the coronary arteries by fat deposits leading to diminished blood flow to the heart muscle itself

Electrocardiogram. An electrical measurement of the heart's electrical activity and basic mechanical functioning

Epithelioma. A cancer arising from the skin or lining of the oral cavity. If discovered early it can be eradicated with surgery and chemotherapy

Executive Health Program. A clinical program offering medical treatment to General Officers, General Officer's spouses, Ambassadors, Air Attaches, and VIPs. Consists of a clinic with at least one dedicated physician, an Executive Protocol Officer, and clerical support as well as an escort.

Extravasation. Blood loss due to uncontrolled bleeding from a body orifice or injury

Granulomatous Colitis. An antiquated term for a disease of the small or large intestine now commonly referred to as Crohn's Disease and Ulcerative Colitis, respectively

Hypertension. High blood pressure

Hyperthyroidism. A condition of the human thyroid gland whereby excessive amounts of thyroid hormone are secreted into the blood stream leading to multiple symptoms; primarily increased arousal, anxiety, increased pulse rate, blood pressure and heart electrical abnormalities

Interspace. When referring to the ribs, the flesh (actually muscle) that lies between one rib and another

Intracranial Pressure. The fluid pressure inside the skull containing the brain. Excess pressure decreases blood circulation and is closely associated with coma or death

Intravenous Fluids. Sterile fluids introduced into the body through an external vein by a needle and connecting tube

Maxilla. The upper jaw bone

Myocardial Infarction. Commonly known as "heart attack." It occurs whenever the heart muscle (myo=muscle, cardial=heart) is deprived of sufficient blood flow or oxygenated blood from the coronary arteries

Myxosarcoma. A rare form of tissue cancer that has no exact known origin. Difficult to treat with anti-cancer drugs and frequently fatal

Nelaton Probe. An antiquated instrument used by surgeons to explore body cavities. Approximately the size of a tooth brush but ¼ the thickness and made from polished steel

Peritoneal Lavage. A process whereby a large needle is inserted into the abdominal cavity in order to introduce sterile fluids which are then withdrawn to look for internal bleeding or for cancer cells floating in the abdominal cavity's fluid

Posterior. Back part of a body part

Prognosis. The predicted outcome of an illness

Prostate. A male gland in the genital/anal area that is involved in sperm composition

Resuscitation. To revive a patient's vital signs, i.e., breathing, pulse, and blood pressure by either external manipulation or medications

Stress Test. An electrocardiogram taken while an individual performs strenuous exercise that measures the blood flow to the heart muscle

Thyroid Function Tests. A blood test that discerns the amount of thyroid hormone being produced by the thyroid gland

Uterine Cancer. Malignant cancer of the female womb. High mortality (death) rate

Verrucous Carcinoma. A malignant cancer of the skin or oral cavity which is usually well partitioned from underlying tissues and easily identified. Its nature is such that it does not spread until advanced and is treatable with surgical extraction

VIP Syndrome. A phenomenon that occurs in a healthcare setting whereby the mere presence of an influential patient exerts a distracting influence upon the medical staff and their functioning

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